U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 22 June 2006

In the Matter of:

ERNEST E. WARD,
Claimant

v.

LONG PIT MINING COMPANY,
Employer

and

U.S. FIDELITY & GUARANTY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Case No. 2004-BLA-6534

Appearances:

Christie Hutson, Lay Representative
REACHS Community Health Center
LaFollette, Tennessee 37766
For the Claimant

David Murphy, Esq.
Clark & Ward
Louisville, Kentucky 40202
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provides compensation and other benefits to living coal miners who are totally disabled due

to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, Ernest E. Ward, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing in this claim on March 29, 2005, in Knoxville, Tennessee. All parties were afforded full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") at 14-46. Director's Exhibits ("DX") 1-24, Employer's Exhibits ("EX") 1-3, and ALJ Exhibit 1 were admitted into evidence. Employer's Exhibit 4, containing eight x-ray readings by Dr. Dahhan, was excluded because the readings exceeded the permitted number prescribed by 20 CFR § 725.414, and the Employer failed to show good cause for admitting the exhibit. Tr. at 7-13. The record was held open 60 days post-hearing to allow the parties to submit closing briefs. Tr. at 47. Both parties submitted briefs.

Upon review of the Director's exhibits after the hearing, I discovered that the Employer had submitted two re-readings of the Department of Labor-sponsored x-ray to the District Director of the Office of Workers' Compensation Programs ("OWCP"): one by Dr. Broudy, found in DX 9, and listed on the Employer's Evidence Summary Form; and a second by Dr. Dahhan, found in DX 10, but not listed on the Employer's Evidence Summary Form. 20 CFR 725.414(a) permits each party to submit only one rebuttal re-reading of the Department-sponsored x-ray. Although the Claimant did not object to DX 10, the Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-169 (2004). I therefore find that DX 10 should be stricken from the record.

Comparison of the Employer's Evidence Summary Form, its closing brief, the transcript, and the exhibits, discloses that the exhibits and exhibit numbers referenced in the Employer's Evidence Summary Form and in its closing brief do not match the exhibits admitted at the hearing. To clarify the record, the Employer's Exhibits are: EX 1, the deposition of Dr. Dahhan, with attached deposition exhibits (Deposition Exhibit ("Dep. Ex.") 1, Dr. Dahhan's curriculum vitae; Dep. Ex. 2, the series of eight x-ray readings also offered as EX 4, excluded from evidence at the hearing; Dep. Ex. 3, the results of the pulmonary function tests, arterial blood gas studies and EKG administered by Dr. Dahhan on August 30, 2004; and Dep. Ex. 4, Dr. Dahhan's reading of the x-ray taken as part of his examination of the Claimant August 30, 2004); EX 2, the deposition of Dr. Broudy, with attached Dep. Ex. 1, Dr. Broudy's curriculum vitae; and EX 3, Dr. Broudy's interpretation of an x-ray taken June 24, 2002.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on October 29, 1980. DX 1. That claim was denied on January 12, 1981, when the District Director, OWCP, determined that the Claimant did not have pneumoconiosis, that the disease was not caused by coal mine employment, and that the Miner was not disabled due to pneumoconiosis. DX 1. The Claimant did not appeal.

The Claimant filed his current claim for benefits on March 14, 2003. DX 3. Benefits were denied by the District Director, OWCP, on April 1, 2004. DX 21. The District Director found that the Claimant established the existence of pneumoconiosis caused by coal mine employment, but that he was not disabled by the disease. The Claimant appealed on April 23, 2004 (DX 22), and the claim was forwarded to the Office of Administrative Law Judges for a formal hearing on July 7, 2004. DX 24.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on March 14, 2003. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). Pursuant to 20 CFR § 725.309(d) (2005), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2005). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer and the Director are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the Claimant has demonstrated a material change in conditions as required by § 725.309.

6. The number of years of coal mine employment by the Claimant.

DX 24; Tr. 5-6, 11.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the hearing, and in a deposition taken by telephone on November 3, 2003. DX 18. The Claimant was born in 1935, and was 70 years old at the time of hearing. Tr. at 14. He is a high school graduate. DX 18 at 9. He has been married for 48 years. Tr. at 14.

According to employment histories submitted by the Claimant to the Department of Labor, and his testimony, the Claimant began working in the mines in 1957. He left the mines in 1984. DX 4, 6. He testified at hearing that he worked in coal mine employment for 26 years. Tr. 14; *see also* DX 3, DX 18. Mr. Ward testified that he worked in coal mine employment from 1957-1958 and he was then drafted into the Army. Tr. at 14. He worked for Hurricane Mountain Coal Company after his release from the Army in 1960 until the mine shut down in 1972. Tr. at 15. He then went to Long Pit Mine from 1972 through about 1979. Tr. at 19; *see also* DX 18. His work for Hurricane Mountain Coal Company was documented in his initial claim by a written statement signed by Ed Claiborne, a W-2 for l969, and paycheck stubs from relevant time periods. DX 1. He testified that Social Security records showing employment in the Finance and Accounting office represented earnings made while in the Army inactive reserve. Tr. at 41. He could not explain why employment with Hurricane Mountain Coal Company did not appear in Social Security earnings records from 1961 through 1972. Tr. at 41-42. Nonetheless, I credit his testimony that he worked in the mines during that period. The Claimant has recited a consistent history of his coal mine work throughout the proceedings on his claim, and to his treating doctors. Based on his testimony, Social Security earnings record, the written statement by Ed Claiborne, and W-2 and pay stubs from Hurricane Mountain Coal Company, I find that the Claimant had at least 21.5 years of coal mine employment. His last coal mine employment was in the State of Tennessee. DX 4. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The Claimant testified that he stopped working in the 1980's because he became disabled. Tr. 22. He had a lot of back problems, and his breathing kept getting worse. Tr. 22-23. The doctor who treated him during his heart surgery, Dr. Crater, told him he had black lung. He could not afford Dr. Crater's fee to obtain a written report. Tr. 24-25. At the time of the hearing, he was using oxygen 24 hours per day. Tr. 25. He has had pneumonia four or five times. Tr. 26. He uses inhalers and nebulizer treatments. He has also had heart surgery, diabetes, high blood pressure, and other medical problems. Tr. 27.

The Claimant stated that he started smoking near adulthood (DX 18 at 36), that he used to smoke about a half pack of cigarettes per day and that he stopped smoking in 1987. Tr. at 28. Dr. Baker noted 40+ years of cigarette smoking at a rate of less than one pack per day. DX 8.

Dr. Dahhan noted 32 pack years of cigarette smoking, one pack per day from 1955-1987. EX 1. Dr. Broudy reviewed the medical records in this claim and noted between 20-50 pack years of cigarette smoking. EX 2. I find Dr. Dahhan's record the most specific and detailed, and find that the Miner has a smoking history of one pack of cigarettes per day, from 1955-1987, or 32 pack years.

Medical Evidence

Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was denied by the District Director on January 12, 1981, and the denial became final one year later. For the reasons explained below I have found that the Claimant has established that he has pneumoconiosis with the evidence submitted in connection with the current claim. This constitutes a material change in conditions. Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2005). 20 CFR § 725.309(d)(1) (2005). Moreover, no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2005).

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in the current claim. As noted above, some x-ray readings offered by the Employer have been excluded from evidence to conform to the limitations contained in 20 CFR § 725.414 (2005).

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and

Health (NIOSH) and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[1] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/24/02	DX 11 Crater "Interstitial markings … may be consistent with a pneumoconiosis"[2]	EX 3 Broudy, B 0/0	
06/03/03	DX 8 Baker, B 1/0	DX 9 Broudy, B 0[3]	DX 8 Barrett, BCR, B Read for quality only, Quality 1

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

[2] This x-ray was taken in connection with treatment, and is therefore admissible under 20 CFR § 725.414(a)(4). The Claimant did not rely it as one of the x-rays permitted under § 414(a)(2)(i). *See* the Claimant's revised Evidence Summary Form submitted by facsimile on March 9, 2005. Nor did the Claimant object to admission of Dr. Broudy's re-reading of this x-ray. Although technically not proper rebuttal under § 414(a)(3)(ii), in the context of this case, I find that Dr. Broudy's re-reading should nonetheless be admissible as part of his review of the Claimant's treatment records.

[3] As noted above, a second re-reading of this x-ray, by Dr. Dahhan on behalf of the Employer, found in DX 10, has been stricken from the record.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/17/03	DX 11 Cappiello, BCR, B 1/1 DX 11 Cohen BCR "suggestive of early pneumoconiosis."[4]	EX 1 Dahhan, B	
08/30/04		EX 1 (Dep. Ex. 4) Dahhan, B 0/0	

The only x-ray interpretation from the prior claim appears on the following chart:

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12/22/80		DX 1 Swann, B 0/0	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. A greater the resistance to the flow of air demonstrates a more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age/ Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression

[4] This x-ray was taken in connection with treatment, and is therefore admissible under 20 CFR § 725.414(a)(4). The Claimant also designated it as one on which he relies pursuant to 20 CFR § 725.414(a)(2)(i). *See* the Claimant's revised Evidence Summary Form.

[5] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As there is a variance in the recorded height of the miner from 68.1" to 70", I have taken the mid-point (69") in determining whether the studies qualify to show disability under the regulations. Only one of

Ex. No. Date Physician	Age/ Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 11 Crater 06/07/00	65 70”	1.90 1.69	2.66 2.33	71% 73%	-- --	No Yes	
DX 8 06/03/03 Baker	68 68.75”	1.98	3.41	58%	--	No	Mild obstructive defect
DX 11 01/14/04 Dhandapani	68 70”	-- 2.33	-- 3.08	-- 75.7%	--	No	Only one trial
EX 1 (Dep. Ex. 3) 08/30/04 Dahhan	69 173 cm (68.1”)	1.93 2.04	2.64 2.76	73% 74%	36 26	No	Less than optimum effort. Mild reversible obstructive defect. No evidence of restrictive abnormalities.

The following chart summarizes the results of the only pulmonary function study available in connection with the prior claim.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1	45 70”	2.65	3.65		91	No	

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

---

the tests is qualifying to show disability whether considering the mid-point, or the heights listed by the persons who administered the testing.

The following chart summarizes the arterial blood gas studies available in the current claim. On his Evidence Summary form, the Claimant designated an April 6, 2004, arterial blood gas study by Dr. Pietrasz as one of two on which he relied to support his claim. This study was not included in the Director's exhibits; nor was it offered into evidence at the hearing. It is not, therefore, part of the evidentiary record in this claim, and cannot be considered. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b)(2005).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 8	06/03/03	Baker	44	65	No	Exercise contraindicated due to ischemic heart disease. Moderate resting hypoxemia.
EX 1 (Dep. Ex. 3)	08/30/04	Dahhan	51.5	116	Yes	Patient on oxygen. Unable to exercise due to breathing problems

The following chart summarizes the only arterial blood gas study available in connection with the prior claim.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	12/22/80	Toyohara	38.3 37.0	84.9 83.3	No No	Patient became exhausted and exercise analysis was stopped.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms,

pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains the following medical opinions relating to this case.

The record contains medical treatment notes from Oak Ridge Hospital, Methodist Medical Center and LaFollette Medical Center for heart related conditions, including stenting, a myocardial infarction, and three-vessel bypass surgery in February 2001. DX 11. Lungs were clear to auscultation or showed diminished breath sounds with scattered wheezes. Diagnoses included COPD with possible pneumoconiosis. A 20-50 pack year cigarette habit was listed, with smoking having ceased in 1987. The records also noted a history of intermittent coal mine employment. Chest x-rays showed mild lung field infiltrates with no analysis given. The Claimant was referred to Dr. Glenn Crater for a consultation on June 24, 2002, due to concern about his breathing. Dr. Crater is board certified in internal medicine, pulmonary disease and critical care. He had seen the Claimant once before, for a preoperative consultation. During the 2002 examination, Dr. Craters observed decreased breath sounds but the chest was clear. Blood gas showed increased AA gradient, otherwise normal. Pulmonary function tests revealed some obstruction, and both intrinsic and extrinsic restriction. X-ray showed "…No infiltrates or masses. Interstitial markings mildly increased in pattern that may be consistent with a pneumoconiosis." Dr. Crater's impression included a component of COPD [chronic obstructive pulmonary disease], a component of CWP [coal workers' pneumoconiosis], and a component of restriction due to body habitus and weight. In his plan for treatment, he said,

> There is little else to do besides continue Combivent and Theo-Dur. Aggressive management of heart disease. I suspect there is a mild component of CWP but he doesn't seem to have progressive fibrosis. We will follow him on a yearly basis her, sooner if he has problems.

DX 11. Dr. Crater did not offer an opinion on the Claimant's ability to work.

Dr. Glen Baker, a Board-certified Internist, Pulmonologist and B reader, examined the Claimant on behalf of the Department of Labor on June 3, 2003. DX 8. He listed 26 years of coal mine employment, 40+ years of cigarette smoking at a rate of less than one pack per day quitting in 1987, and symptoms of sputum, wheezing, dyspnea, cough, hemoptysis, chest pain, orthopnea, and ankle edema. Past medical history was significant for heart related disease, elevated cholesterol, hernia, and disc and shoulder surgeries. On examination, lungs were normal, chest x-ray was read as 1/0, pulmonary function study showed mild obstructive defect, arterial blood gases showed moderate resting hypoxemia and an EKG showed normal sinus

rhythm, left axis deviation, and left bundle branch block. Dr. Baker diagnosed coal workers' pneumoconiosis, based on a history of coal dust exposure and a positive x-ray; COPD, due to coal dust exposure and prior cigarette smoking, based on pulmonary function testing; hypoxemia, due in part to coal dust exposure demonstrated by arterial blood gas testing; chronic bronchitis, due in part to coal dust exposure, based on reported symptoms; and ischemic heart disease, status post coronary artery bypass graft, based on ASHD. He opined that the Miner suffers a mild impairment, due in part to pneumoconiosis. He based his disability diagnosis on pulmonary function and arterial blood gas results. He concluded that the Claimant retained the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment. Dr. Baker referred the Claimant to his family doctor to follow up the abnormal x-ray.

Dr. A. Dahhan, a Board-certified Internist, Pulmonologist and B reader, reviewed several x-rays of the Claimant's chest on July 6, 2004, examined the Claimant on August 30, 2004, and was deposed on December 7, 2004, on behalf of the Employer. EX 1. Dr. Dahhan read the series of x-rays in advance of the examination to be negative; however, I have excluded the readings from evidence. At the examination, Dr. Dahhan noted the Miner's age, twenty-six years of coal mine employment ending in 1979, thirty-two pack years of cigarette smoking (one pack per day from 1955 to 1987), ongoing use of prescribed oxygen and inhalers, and a history of coronary artery disease post bypass surgery. Dr. Dahhan performed a physical examination (good air entry both lungs), arterial blood gas test (normal), pulmonary function test (mild, reversible obstructive ventilatory defect with significant response to bronchodilation, no evidence of restrictive ventilatory abnormalities), and x-ray (0/0, emphysema, cardiac enlargement). Based on the data collected Dr. Dahhan opined that the Claimant does not suffer from coal induced lung disease. He based his opinion on a negative x-ray, the variable nature of the Miner's obstructive defect, normal arterial blood gases, and his physical examination of the chest. He opined that the mild obstructive pulmonary defect detected by pulmonary function testing was due to 30 plus years of cigarette smoking because pneumoconiosis is a fixed permanent condition and the Miner has significant variation in pulmonary function when exposed to inhalers. Such a finding is inconsistent with a diagnosis of pneumoconiosis. Dr. Dahhan did not state whether or not the Claimant would be able to perform his last job in the mines or comparable work, but he did rate the Miner's pulmonary defect as "mild."

Dr. Bruce C. Broudy, a Board-certified Internist, Pulmonologist and B reader, performed a records review and was deposed on behalf of the Employer on January 18, 2005. EX 2. Dr. Broudy noted a previous history of Legionnaire's disease, several heart attacks, at least two angioplasties, and triple bypass surgery. Records demonstrated a smoking history of between 20-50 pack years. Based on the records reviewed, Dr. Broudy opined that the Claimant does not suffer from pneumoconiosis. He noted that pulmonary function testing exceeded the minimum federal criteria for disability and he opined that the Miner is not totally disabled under the regulations. He stated that the x-rays he reviewed were negative. Dr. Broudy opined that symptoms and objective testing abnormalities were explained by the Claimant's cardiac disease and smoking history. He stated that dyspnea is a common symptom of cardiac disease.

Dr. William K. Swann examined the Claimant on behalf of the Department of Labor in connection with his initial claim on December 22, 1980. DX 1. Dr. Swann's qualifications are

not in the file, and he is not listed on the American Board of Medical Specialties web-site. He was a B reader at the time he examined the Claimant. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Ward worked in the mines for 20 years. He reported a smoking history of 1/2 pack per day for 10 years. No abnormalities were noted on the chest examination. Dr. Swann read the x-ray as completely negative, also with no abnormalities noted. He made no comments about the results of the pulmonary function or arterial blood gas studies. He left the space for diagnosis blank, and checked "No" to the question whether the diagnosed condition related to dust exposure.

The record of the initial claim also includes the report of a lung scan performed on the Claimant on January 29, 1980, which suggested the possibility of pulmonary embolus.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, the Claimant's medical records indicate that he has been diagnosed with pneumoconiosis, and chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Ward had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

There are both positive and negative x-ray readings in this case. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The June 24, 2002, x-ray was read as "consistent with a pneumoconiosis" by Dr. Crater, but it was not classified as required by the regulations. Dr. Crater does not appear on the NIOSH list as a B reader. Moreover, the x-ray was read as negative by Dr. Broudy, who is a B reader. I find this x-ray to be negative.

The June 3, 2003, x-ray film was read as positive by Dr. Baker, a B reader, and as negative by Dr. Broudy, a B reader. As the film has opposing readings by equally qualified readers, I find this film to in equipoise, and therefore indeterminative of the presence of pneumoconiosis.

The November 17, 2003, x-ray film was read as positive by Dr. Cappiello, a Board-certified Radiologist and B reader, and as negative by Dr. Dahhan, a B reader. Dr. Cohen stated that the film was "suggestive" of early pneumoconiosis. Dr. Cohen's interpretation is equivocal and unclassified, and I give it no weight. Noting Dr. Cappiello's dual credentials, I give greater weight to his interpretation and find that the November 17, 2003, x-ray film is positive for pneumoconiosis.

The August 30, 2004, was read as negative by Dr. Dahhan, a B reader. There are no positive readings.

Based on all of the readings, one x-ray is positive, one is in equipoise, and two are negative, including the most recent x-ray. I find that the newly submitted x-rays are insufficient to establish the existence of pneumoconiosis under 20 CFR § 718.202(a)(1).

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155

(1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2005). The Sixth Circuit has interpreted this rule to mean that

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted). In this case, the newly submitted record contains treatment notes from Oak Ridge Hospital, Methodist Medical Center and LaFollette Medical Center. Although diagnoses lists from the hospital records at times included COPD and possible pneumoconiosis, no basis for either diagnosis was listed. I find those diagnoses to be unsupported and I give them little weight. Although Dr. Crater is a pulmonologist and based his opinion on objective testing, he only saw the Claimant twice, the first time for the limited purpose of clearing him for surgery. Hence I cannot give his opinion more weight than any other examining physician.

Dr. Crater and Dr. Baker both diagnosed pneumoconiosis. Both are well-qualified pulmonologists, and both had the opportunity to examine the Claimant. Both had the results of objective testing available to them. Moreover, their conclusions are consistent with the premises underlying the current Department of Labor regulations, that coal mine dust can cause chronic obstructive pulmonary disease (legal pneumoconiosis), and that smokers who mine have an additive risk for COPD. *See* the commentary by the Department of Labor which accompanied the final rules, 79220 et seq. (2000), at 79938-79943.

Dr. Dahhan is also a well-qualified pulmonologist. Dr. Dahhan's opinion on the existence of pneumoconiosis is problematic because his x-ray readings, found in EX 4 and

Deposition Exhibit 2, have been excluded from evidence because they exceeded the limitations in the regulations. Upon review of his deposition, I conclude that Dr. Dahhan's opinion as to the existence of pneumoconiosis was significantly influenced by his negative interpretations of inadmissible x-ray reports. Moreover, he did not address the existence of legal pneumoconiosis. For theses reasons, I give his opinion little weight.

Dr. Broudy, pulmonologist and a B reader, performed a records review at the request of the Employer. A non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984). Dr. Broudy diagnosed no pneumoconiosis. He based his opinion on prior medical histories including Legionnaires Disease, coronary artery disease and triple bypass surgery, on negative x-ray evidence, and on pulmonary function testing which consistently exceeded the minimum criteria for disability. He was aware of Dr. Crater's and Dr. Baker's opinions, and the basis for them. He opined that recorded symptoms and minor testing abnormalities were completely and adequately explained by the Miner's smoking history and ongoing heart disease. However, he offered no convincing explanation why coal dust should be excluded as a contributing cause of the Claimant's obstructive disease.

I find that the well-documented and reasoned opinions of Dr. Crater and Dr. Baker are entitled to greater weight than those of Dr. Dahhan and Dr. Broudy. I conclude that the Claimant has established that he has legal pneumoconiosis based on the opinions of two examining physicians. This conclusion is not undermined by the negative opinion of Dr. Swann, based on an examination much more remote in time.

Total Pulmonary or Respiratory Disability.

Although I have found that new evidence submitted in connection with the current claim shows that the Claimant has pneumoconiosis, his claim must still fail, because he has not established that he is totally disabled by a pulmonary or respiratory impairment.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b),(d)(2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Ward suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh

all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2)(2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

The record contains five pulmonary function studies. Four of the studies are nonqualifying. The June 7, 2000, study recorded nonqualifying readings before bronchodilation and qualifying readings post-bronchodilation. More weight may be given to the results of a recent ventilatory study over the results of an earlier study. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). The lone qualifying reading was recorded on the oldest test in record and I give greater weight to the newer tests which more accurately measure the Miner's current capacity. Reviewing all newly submitted pulmonary function studies, I find that pulmonary function testing does not demonstrate total pulmonary or respiratory disability.

The newly submitted record contains two arterial blood gas studies. Dr. Dahhan's August 30, 2004, test produced qualifying readings while the June 6, 2003, test was nonqualifying. The evidence would appear to be in equipoise. The Department of Labor believes, however, "that evaluation of conflicting medical evidence requires careful consideration of a wide variety of disparate factors affecting the credibility of that evidence. The presence of these factors makes it unlikely that a fact-finder will be able to conclude that conflicting evidence is truly in equipoise." Regulations Implementing Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,924 (2000).

While Dr. Dahhan reported qualifying readings, he stated that the Miner was on two liters/minute of oxygen via a nasal prone at the time of the test, and that arterial blood gas readings, when reviewed with pulmonary function testing and a normal chest evaluation, demonstrated only mild, partially reversible, obstructive defect. While Dr. Dahhan's testing produced readings which would qualify under the regulations, Dr. Dahhan did not interpret his own readings as totally disabling. I find that newly submitted arterial blood gas readings do not establish total disability under the Act.

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work. No physician in the newly submitted record opines that the Miner is totally disabled.

As a result of non-supportive pulmonary testing, non-supportive arterial blood gas testing, and as the record contains no medical opinions stating that Claimant suffers from total pulmonary or respiratory disability, I find that newly submitted evidence fails to establish total disability under § 718.204(b)(2). These results are unchanged when the medical evidence from the initial claim is considered.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he is totally disabled by a pulmonary or respiratory disability, he is not entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The award of a representative's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Earnest Ward on March 14, 2003, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).